

Birth & Death 00948

MARYLAND STATE DEPARTMENT OF HEALTH (19)
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Charles
 City or town La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:

Length of mother's stay in County.....
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Charles
 City or town Welcome
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If RURAL give LOCATION)

3. Name of child Female Blackiston

5. Sex Female | 6. Twin or triplet.....

4. Date of birth April 9 1947 Hour 2:30 P.M.

7. No. of weeks pregnancy 23 wk.

FATHER OF CHILD

8. Full name Charles Bowman
 9. Color Cal. 10. Age at time of this birth 29 yrs.
 11. Usual occupation Laborer

MOTHER OF CHILD

12. Full maiden name Mary Eileen Blackiston
 13. Color Cal. 14. Age at time of this birth 26 yrs.
 15. Usual occupation Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor?..... During labor?.....

18. Pregnancy, complications of.....

19. Labor: (a) Complications of.....

(b) Induced? No

20. (a) Was there an operation for delivery? No

(Yes or No)

(b) State all operations, if any.....

(c) Did child die before operation?.....

During operation?.....

23. (a) Burial (b) Date thereof 4-9-47
 (Burial, cremation or removal) Welcome, Md. (day) (year)

(c) Cemetery or crematory St. John's - P. J. O'Donovan

24. (a) Funeral director Frank Wathen

(b) Address Welcome, Md.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia etc., try to add cause thereof.

(a) Fetal causes Prematurity (Unknown)

(b) Maternal causes Unknown

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature E. Eileen M.

(Specify if M.D., midwife, or other)

Address La Plata, Md.

25. (a) 4-9-47 (b) Julian H. Passy
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

Child lived 15 minutes

V. S. A10

RECEIVED

APR 17 1947

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County..... Charles

City or town..... La Plata and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Charles

City or town..... La Plata and
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Francis Boorman

3. (b) Social Security Number

4. Sex..... M 5. Color of race..... Cal 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Mary

7. Birth date of deceased (mo., day, yr.)..... Feb 28 - 1891

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

56

1

6

hrs. min.

9. Birthplace.....

Baltimore and

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

FATHER

12. Name..... Charles Boorman

13. Birthplace.....

Baltimore and

14. Maiden name.....

Caroline Cape

15. Birthplace.....

Baltimore and

16. Informant.....

Mary Boorman

Address.....

Bryantown and

17.

Burial

Date thereof.....

4-5-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St Mary

Location.....

Bryantown and

18. Funeral director.....

H. H. H. H. H.

Address.....

Waldorf and

19.

4-5-

1947

(Date rec'd by registrar)

Julius H. Posey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4-3-47 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-2

1947

to 4-3

1947

and that I last saw him alive on

4-2

1947

Immediate cause of death.....

Coronary Thrombosis

DURATION

4-2-47

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE.....

J. H. H. H.

M. D. or other

Address.....

La Plata Md

Date signed 4-3-47

ARTESIAN WELLS

WATER CONTROL

RECEIVED

APR 7 1947

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

CERTIFICATE OF DEATH

Reg. Dist. No. *1000*

00950

1. PLACE OF DEATH County <i>Charles</i> City or town <i>La Plata Md</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <i>Physicians Memorial Hospital</i> How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <i>Md</i> County <i>Charles</i> City or town <i>Malcolm</i> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____		
3. (a) FULL NAME <i>Katie Brooks</i>			3. (b) Social Security Number		
4. Sex <i>F</i>	5. Color or race <i>Gal</i>	6. (a) Single, married, widowed, or divorced <i>Married</i>			
6. (b) Name of husband or wife <i>Thomas Brooks</i>					
6. (c) If alive, give age _____ years					
7. Birth date of deceased (mo., day, yr.) <i>1893</i>					
8. AGE: Year <i>53</i>		Months	Days	If less than one day _____ hrs. _____ min.	
9. Birthplace <i>Malcolm Md</i> (Town, county, and state)					
10. Usual occupation <i>House Work</i>					
11. Industry or business					
MOTHER FATHER	12. Name <i>James Skinner</i>				
	13. Birthplace <i>Chas Co Md</i>				
	14. Maiden name <i>Mary Opelona Skinner</i>				
15. Birthplace <i>Charles Co Malcolm</i>					
16. Informant <i>Thomas Brooks</i> Address <i>Brookley wick Md</i>					
17. Burial (Burial, cremation, or removal. Which?) <i>4-6-47</i> Date thereof (month) (day) (year) Cemetery or crematory <i>John Wesley</i> Location <i>Aquasco Md</i>					
18. Funeral director <i>Huntt & Ryan</i> Address <i>Wesley Md</i>					
19. 4-5-47 (Date rec'd by registrar) <i>Julius H. Passey</i> Registrar					
MEDICAL CERTIFICATION					
20. DATE OF DEATH <i>April 3 1947</i> at <i>6:05 PM</i>					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>March 27 1947</i> to <i>April 3 1947</i> and that I last saw her alive on <i>April 2 1947</i>					
Immediate cause of death <i>Cerebral hemorrhage & cardiac decompensation</i>					
Due to <i>Hypertensive heart disease</i>					
Due to _____					
Other conditions _____					
(Include pregnancy within 3 months of death)					
Major findings of operations _____					
Autopsy results _____					
PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following:					
Accident, suicide, or homicide _____ Date of _____					
Where did injury occur? _____ (City or town) _____ (County) _____ (State)					
Injured at home, farm, industry, public place (where?) _____					
Means of injury _____ Injured at work? _____					
23. SIGNATURE <i>Armed R. Lapin M.D.</i> M. D. or other _____					
Address <i>Aquasco Md</i> Date signed <i>April 3 1947</i>					

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APR 7 1947

BUREAU V &

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00951

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Marshall's Corner
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. Marshall's Corner
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Ida Elizabeth Chase

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Apr. 25, 1947
6. (c) If alive, give age years
8. AGE: Years Months Days If less than one day
18 hrs. min.

9. Birthplace La Plata, Charles, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Shant Chase

13. Birthplace Charles County, Md.

14. Maiden name Leahanna Cecelia Butler

15. Birthplace Charles County, Md.

16. Informant Clarence Butler, (Grandfather)

Address La Plata, Md.

17. Burial Date thereof 4-26-47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Grave of Home

Location La Plata, Md.

18. Funeral director Clarence Butler

Address La Plata, Md.

19. 4-26 19 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47 at 2:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 19 47, to Apr. 26 19 47

and that I last saw her alive on April 25 19 47

Immediate cause of death Prematurity - 6 mos. gestation

Due to Congenital syphilis

Due to probable factor

Due to (Mother open case; baby shows no external signs)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. MacKinnon, M.D.

Address La Plata, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1947
BUREAU C. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

00952

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH: County <u>La Charles</u> City or town <u>La Plata md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Physicians Memorial Hospital</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>md</u> County <u>Charles</u> City or town <u>La Plata md</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Edward J. Dyer</u>				3. (b) Social Security Number <u>Dyer</u>			
4. Sex <u>M</u>		5. Color or race <u>C</u>		6. (a) Single, married, widowed, or divorced <u>W</u>			
6. (b) Name of husband or wife <u>Wilhelmina Finnik</u>				6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>1877</u>				8. AGE: Years <u>68</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.			
9. Birthplace <u>Chas Co md</u> (Town, county, and state)				10. Usual occupation <u>Farming</u>			
11. Industry or business <u>C. Dyer</u>				12. Name <u>Chas Co md</u>			
13. Birthplace <u>Wilhelmina</u>				14. Maiden name <u>Wilhelmina</u>			
15. Birthplace <u>Cary Dyer</u>				16. Informant <u>La Plata md</u>			
17. Burial, cremation, or removal. Which? <u>Burial</u> Date thereof <u>4-14-47</u> (month) (day) (year) Cemetery or crematory <u>St Joseph</u> <u>Pomquet md</u> Location <u>South</u> <u>Harbor</u>				18. Funeral director <u>Walday md</u> Address <u>4-12</u> (Date rec'd by registrar) <u>19</u> <u>4-11-47</u> Registrar <u>Th L. Meller</u>			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>April 11</u> 19 <u>47</u> at <u>4:30</u> PM							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4-9</u> 19 <u>47</u> to <u>4-11</u> 19 <u>47</u> and that I last saw him <u>alive</u> on <u>4-11</u> 19 <u>47</u>							
Immediate cause of death <u>Cerebral hemorrhage</u>							
Due to <u>Trauma to left side of skull: hit with club - assailant found guilty of second-degree murder.</u> <u>C.S.A.</u>							
Other conditions (Include pregnancy within 8 months of death)							
Major findings of operations Date of op. _____							
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>Homicide</u> Date of <u>April 9th, 1947</u> Where did injury occur? <u>Mr. Marshall's Carvers</u> (County) <u>Maryland</u> (State) Injured at home, farm, industry, public place (where?) <u>on highway</u> Means of injury _____ Injured at work? _____							
23. SIGNATURE <u>E. Dyer</u> M. D. or other _____ Address <u>La Plata, Md.</u> Date signed <u>4-11-47</u>							

RECEIVED

APR 17 1947

SECRET 18

Evidence for change of age
shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-2)

FILM No. G 110 MAY 12 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County Charles
City or town Mt Victoria
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
City or town Mt Victoria
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

ELLEN DYSON

3. (b) Social Security Number

4. Sex

F

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

James

7. Birth date of

deceased (mo., day, yr.)

Aug 13 - 1888

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

67 61

hrs. min.

9. Birthplace

Charles Mt

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

24 April

19 47

at 7:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 April

19 47

to 24 April

19 47

and that I last saw her alive on 24 April 47

Immediate cause of death

Cerebral vascular

accident

DURATION

3 hrs

Due to

Essential hypertension

many years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. J. Wooddy

M. D. or other

Address

LaBata, Md

Date signed

4/29/47

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 1 1947
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 104

1. PLACE OF DEATH: *Charles*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *60 years*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*md*..... County.....*Charles*.....
City or town.....*Hayside*.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *George E. Floyd*

3. (b) Social Security Number

4. Sex *m* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced *married*
6. (b) Name of husband or wife.....*mailed Floyd*
7. Birth date of deceased (mo., day, yr.) *Oct. 7-83* 8. (c) If alive, give age *63* years
8. AGE: Years *63* Months *6* Days *23* If less than one day
.....hrs.min.

9. Birthplace.....*Hayside - Charles md*
(Town, county, and state)
10. Usual occupation.....*Electrician*

11. Industry or business

FATHER 12. Name.....*Andrew P. Floyd*
13. Birthplace.....*Hayside*
MOTHER 14. Maiden name.....*Mary E. Bailey*
15. Birthplace.....*Isles*

16. Informant.....*E. K. Floyd*
Address.....*Rock Point, md*

17. *Married* Date thereof.....*Sept. 1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....*Holy Ghost*
Location.....*Isles*

18. Funeral director.....*Huntt + Ryson*
Address.....*W. Leonard*

19. *4/30/47* 19.....*W. Leonard*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *4-29-1947* at *2 P. M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4-26-1947 to *4-29-1947*
and that I last saw him alive on *4-29-1947*

Immediate cause of death

DURATION

Due to.....*Heart Incontinence*
Due to.....
Other conditions.....*Alcoholism*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....*V. B. Haydon*

M. D. or other

Address.....*Hayside* Date signed.....*4-30-47*

CERTIFICATE OF DEATH

RECEIVED

MAY 1 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 106

00955

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
City or town.....
Street No.....
(If outside city or town limits, write RURAL and give nearest town)
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
43 hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 47 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Suffocation

Due to Smoke inhalation result of mattress fire in his home

Due to

Other conditions 2nd degree burns lower extremities principally

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 4-25-47
Where did injury occur? 44 Highland PI - Potomac Heights Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fire, Suffocation Smoke Injured at work? NO

23. SIGNATURE

Frank G. Susan M. D. or other
Address Indian Head Md Date signed 4-25-47

Classified
by [illegible]
on [illegible]

April 22 1947

Male White
Kiss 2nd 2nd 2nd

of [illegible]
[illegible]
[illegible]

RECEIVED
MAY 9 1947
BUREAU 78

4-22-47
[illegible]
[illegible]
[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134-P

CERTIFICATE OF DEATH

Reg. Diat. No. 100

00956

1. PLACE OF DEATH:

County CharlesCity or town La Plata md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Shesapeake Memorial HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CharlesCity or town Wadsworth md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Russell Springer Jr

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorcedMarried6. (b) Name of husband or wife Agnes7. Birth date of deceased (mo., day, yr.) Oct 30 - 1896 6. (c) If alive, give age _____ years8. AGE: Years 35-0 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Wisconsin
(Town, county, and state)10. Usual occupation Sanitary Service

11. Industry or business _____

12. Name George Springer Sr13. Birthplace Wisconsin14. Maiden name Ellen Stunderson15. Birthplace Wisconsin16. Informant Agnes SpringerAddress Wadsworth md17. Burial, cremation, or removal. Which? Burial Date thereof 4-25-47
(month) (day) (year)Cemetery or crematory Greenwood CemeteryLocation Wadsworth md18. Funeral director Harold BrownAddress Wadsworth md19. 4-25 19 47 Julius A. Pacey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 47 at 4:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 19 47 to April 22 19 47 and that I last saw him alive on April 21 19 47Immediate cause of death Cardiac Failure
and Pneumonia

DURATION

2 daysDue to Cardio-Hepato-Renal Disease and
Gastric HemorrhageDue to Cirrhosis of Liver and
Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Francis J. Cullen Jr. MD
M. D. or other _____Address Shesapeake, md Date signed 4-23-47

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BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex.....
5. Color or race.....
6.(a) Single, married, widowed, or divorced.....
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....
8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.....

9. Birthplace.....
(Town, county, and state)
10. Usual occupation.....
11. Industry or business.....
12. Name.....
13. Birthplace.....
14. Maiden name.....
15. Birthplace.....

16. Informant.....
Address.....
17. Burial.....
(Burial, cremation, or removal. Which?) Date thereof.....
(month) (day) (year)
Cemetery or crematory.....
Location.....
18. Funeral director.....
Address.....
19. H-25.....
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH.....
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from.....
and that I last saw him..... alive on.....
Immediate cause of death.....
DURATION.....
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE.....
Address.....
Date signed.....

MARGIN RESERVED FOR BINDING

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9-45-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
 City or town La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 days
 Hospital, institution, or street address where death occurred:
Physician Memorial Hospital
 How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles
 City or town Bryantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Adrian Thompson

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lena Beata Thompson
 6. (c) If alive, give age 5-1 years
 7. Birth date of deceased (mo., day, yr.) Oct. 11, 1890
 8. AGE: Years 56 Months 6 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Charles County, Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Clayton Thompson

13. Birthplace Chas. Co., Md.

14. Maiden name Elizabeth Swann

15. Birthplace Chas. Co., Md.

16. Informant Lena Thompson

Address Bryantown, Md.

17. Burial Date thereof 5-2-47
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Ignace

Location Belair, Md.

18. Funeral director Huntt & Hyson

Address Nacodoc, Md.

19. 5-2-47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1947 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on April 29, 1947, to _____

and that I last saw him on April 29, 1947

Immediate cause of death Subdural cerebral hemorrhage

Due to Auto accident

Due to Fell out of moving car

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-29-47

Where did injury occur? on Bryantown, Charles, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State highway, Md. 488

Means of injury Fell from moving car Injured at work? No

23. SIGNATURE John I. Mackaway, M.D. Deputy Medical Examiner

Address La Plata, Md. Date signed 4-29-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Bedford
 City or town Overett Route 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David Ross Whitstone

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Fern Byal Whitstone
 6. (c) If alive, give age 58 years

7. Birth date at deceased (mo., day, yr.) August 16, 1888

8. AGE: Years 58 Months 7 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Bedford, Pennsylvania
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John S. Whitstone13. Birthplace Bedford, Penn.14. Maiden name Mary Jane Bowser15. Birthplace Bedford, Penn.16. Informant Mrs Fern WhitstoneAddress Indian Head Md17. Burial Date thereof Apr. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory OverettLocation Overett Pa. W.W. Chambers18. Funeral director Walter J. J. J.Address 517-11-11 St. S.E. Odey Price19. 4-3 19. 47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 2 19 47 at 10:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 2 19 47 to Apr. 2 19 47and that I last saw him alive on Apr. 2 19 47

Immediate cause of death

Cerebral Arteriosclerosismalignant HypertensionDue to Ar. Carlinvascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Geo. O. Bicknell, M.D.Address Marbury, Md. Date signed

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2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 17047

CERTIFICATE OF DEATH

Reg. Dist. No. 703

00960, 0-5
Dist. No.

1. PLACE OF DEATH: Charles Waldorf ind
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... ind County..... C Charles
City or town..... Waldorf ind
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME
Larson A Willett
4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary
7. Birth date of deceased (mo., day, yr.) July 29 - 1907
8. AGE: Years 39 Months 8 Days 22 hrs. min.
9. Birthplace Waldorf ind
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
12. Name Guy Willett
13. Birthplace Waldorf ind
14. Maiden name Virgin Pierce
15. Birthplace Waldorf ind
16. Informant Harber Willett
Address Accokeek ind
17. Burial Date thereof 4-23-47
(Burial, cremation, or removal) (month) (day) (year)
Cemetery or crematory Arlington Memorial
Location Arlington ind
18. Funeral director Hewitt & Son
Address Waldorf ind
19. 4-22 19 47 M. L. Moore Registrar
(Date rec'd by registrar)

3. (b) Social Security Number
579-07-597

MEDICAL CERTIFICATION
20. DATE OF DEATH April 21 19 47 at 4:30 A.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h. alive on 19
Immediate cause of death 1 Fracture - Base of Skull
2 Fractures of Cervical Vertebrae with
Transection of Spinal Cord
Due to 3 Multiple Rib Fractures
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4-21-47
Where did injury occur? Waldorf Charles ind
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) on Rt. 301
Means of Injury Struck by bus. Injured at work?
23. SIGNATURE Larson Larber M.D.
Address LePlata ind. Date signed 4-21-47
M. D. or other

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APR 24 1947

BUREAU V.S.